National Prion Disease Pathology Surveillance Center

TEST REQUISITION FORM

For NPDPSC use only

Ordering Provider (required)

Ordering Provider Name:		
Hospital/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number :	ICD-10 Diagnosis Code:	

Note: Results will be transmitted to Ordering Provider via fax only.

Referring Laboratory

Contact Person:		
Laboratory/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number :	ICD-10 Diagnosis Code:	

Note: Results will be transmitted to the Referring Lab via fax only.

Patient Information (required)

Patient ID (MRN#):		
Last Name:	First Name:	
Sex: ☐ Male ☐ Female	Date of Birth *(mm-dd-yyyy)*:	
Race *(select from the drop-down list)*:	Hispanic/Latino Ethnicity: ☐ Yes ☐ No	
Patient Address:		
City:	State:	Zip Code:
Is patient deceased? ☐ Yes ☐ No	Is there interest in the Autopsy Program? ☐ Yes ☐ No	
Date of Death *(mm-dd-yyyy)*:	Time of Death: ☐ am ☐ pm	

Note: CDC-sponsored brain autopsy is available to definitely diagnose or exclude prion disease. Call 216-368-0587 for details.

Accounts Payable/Billing Information *(if applicable)*

☐ **Check here** if AP/Billing information is the same as **Referring Laboratory**. Otherwise, please fill out the information below.

Name:		
Laboratory/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:

Note: If we are to bill the patient directly for CSF, Blood or Biopsy testing, please fill out the information below. **Please include a copy of the front and back of the insurance card.**

Primary Insurance Information *(if applicable)*

Subscriber Name (if different than patient):		
Insurance Name:	Effective Date *(mm-dd-yyyy)*:	
Policy Number:	Group Number:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:		
Insurance Company Address:		
City:	State:	Zip Code:

Secondary Insurance Information *(if applicable)*

Subscriber Name (if different than patient):		
Insurance Name:	Effective Date *(mm-dd-yyyy)*:	
Policy Number:	Group Number:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:		
Insurance Company Address:		
City:	State:	Zip Code:

Patient Information (required)

Patient ID (MRN#):	Date of Birth *(mm-dd-yyyy)*:
Last Name:	First Name:

Samples Enclosed (required)

Cerebrospinal Fluid

☐ **Cerebrospinal Fluid Panel**
(RT-QuIC, 14-3-3γ (ELISA), Total TAU (ELISA)

Collection Date *(mm-dd-yyyy)*: _____

Volume *(enter number)*: _____ ml.

Whole Blood

☐ **Blood** *(PRNP Genetic Testing)*
***Note**: Testing & Reporting Policies Form **must** be completed and submitted with this form.*

Collection Date *(mm-dd-yyyy)*: _____

Volume *(enter number)*: _____ ml

Biopsy Tissue

☐ **Frozen Brain** *(Western Blot)*

Collection Date *(mm-dd-yyyy)*: _____

Amount: ☐ Whole Brain
☐ Half Brain
☐ Other: _____ ☐ mg ☐ gr

☐ **Fixed Brain**
(Immunohistochemistry (IHC), Hematoxylin & Eosin staining (H&E))

Collection Date *(mm-dd-yyyy)*: _____

Amount: ☐ Whole Brain
☐ Half Brain
☐ Unstained Slides: #_____
☐ Cassettes: #_____
☐ Paraffin Embedded Blocks #_____

For shipping and contact information on CSF, Blood, and Biopsy Tissue, please scan the QR code below, or click the following link:

CSF, Blood, and Biopsy Tissue Shipping Instructions

Autopsy Tissue

☐ **Frozen Brain** *(Western Blot)*

Collection Date *(mm-dd-yyyy)*: _____

Amount: ☐ Whole Brain
☐ Half Brain
☐ Other: _____ ☐ mg ☐ gr

☐ **Fixed Brain**
(Immunohistochemistry (IHC), Hematoxylin & Eosin staining (H&E))

Collection Date *(mm-dd-yyyy)*:

Amount: ☐ Whole Brain
☐ Half Brain
☐ Unstained Slides: #_____
☐ Cassettes: #_____
☐ Paraffin Embedded Blocks #_____

Skin, Lymphoreticular

☐ **Skin Sample**

Collection Date *(mm-dd-yyyy)*: _____

☐ Apex
☐ Posterior to ear
☐ Lumbar spine

☐ **Lymphoreticular Tissue**

Collection Date *(mm-dd-yyyy)*: _____

☐ Appendix
☐ Visceral Lymph Nodes
☐ Spleen

For shipping and contact information on Autopsy, Skin and/or Lymphoreticular Tissue, please scan the QR code below, or click the following link:

Autopsy, Skin, Lymphoreticular Tissue Shipping Instructions

Patient Information (required)

Patient ID (MRN#):	Date of Birth *(mm-dd-yyyy)*:
Last Name:	First Name:

Clinical History and Findings (required)

To be completed by the requesting physician. Also, please attach a clinician's assessment from the EMR.

Clinical Suspicion of Prion Disease

On a scale 1-10, with 1 being LOW and 10 being HIGH, what is the clinical suspicion of prion disease?

Please check one of the boxes:

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Medical & Surgical History

Blood Donations

Has patient ever donated blood? ☐ Yes ☐ No

If yes, donation institution:

Donation year: _____

Do you agree to be contacted by the American Red Cross? ☐ Yes ☐ No

Blood Transfusions

Has patient ever received blood? ☐ Yes ☐ No

If yes, transfusion institution:

Transfusion year: _____

Surgical Procedures

Has the patient had any of these procedures?
Check all that apply:

☐ Neurosurgery
☐ Corneal transplant
☐ Dura mater graft
☐ None

Procedure facility: _____

Date *(mm-dd-yyyy)*: _____

Medical Treatment

Has the patient had any of these treatments?
Check all that apply:

☐ Pituitary gonadotropin (cadaveric)
☐ Human growth hormone (cadaveric)
☐ None

Procedure facility: _____

Date *(mm-dd-yyyy)*: _____

Clinical Symptoms

Illness Onset *(mm/yyyy)*:

☐ Dementia, onset: _____
☐ Ataxia, onset: _____
☐ Myoclonus, onset: _____
☐ Visual Changes, onset: _____
☐ Extrapyramidal, onset: _____
☐ Pyramidal, onset: _____
☐ Psychiatric, onset: _____
☐ Other: _____

Radiographic Findings

NPDPSC offers MRI interpretation at no cost. For assessment, please send brain MRI on disc to our mailing address.

Has patient had MRI suggestive of CJD?

☐ Yes ☐ No ☐ Not performed

Has patient had EEG with periodic sharp wave complexes?

☐ Yes ☐ No ☐ Not performed

Family History

Prion Disease in Family

Is there a Family History of Prion Disease? ☐ Yes ☐ No

If **yes**, what type of Prion Disease?

☐ CJD
☐ GSS
☐ FFI
☐ Other: _____

Name: _____

Relationship to patient: _____

Neurological Diseases in Family

Is there a Family History of Neurological Disease? ☐ Yes ☐ No

If **yes**, what type of Disease?

☐ Alzheimer's
☐ Other:

Relationship to patient:

Social History

Hunting

Has patient ever hunted? ☐ Yes ☐ No

Hunted game:
☐ Deer
☐ Elk
☐ Moose
☐ Caribou
☐ Other

State/Province: _____

Hunting Year(s): _____

Consumption

Has patient ever consumed venison? ☐ Yes ☐ No

Consumed game:
☐ Deer
☐ Elk
☐ Moose
☐ Caribou
☐ Other

State/Province: _____

Consumption Year(s): _____

Travel

Has patient ever travelled to UK, Europe, or Saudi Arabia between years 1980-1996? ☐ Yes ☐ No

Countries: _____

Year(s): _____

Contact and Mailing Address:

NPDPSC Institute of Pathology, CWRU
2085 Adelbert Rd, Room 414
Cleveland, Ohio, 44106-4907

Phone: 216-368-0587
Fax: 216-368-4090
Email: cjdsurveillance@uhhospitals.org

National Prion Disease Pathology Surveillance Center
Testing and Reporting Policies

As a part of our surveillance efforts for CJD, the National Prion Disease Pathology Surveillance Center (NPDPSC) conducts four different tests on the biopsy and autopsy samples we receive:

- **Western blot**: This test demonstrates the presence of the abnormal prion protein, which is believed to cause CJD and other prion diseases. If the abnormal protein is present, the case is positive. The Western blot is the most sensitive test for prion disease. **This test is performed on frozen tissue.**
- **Immunohistochemistry (IHC)/Histology**: In these tests, the neuropathologist examines slides of specially prepared brain tissue to see where the abnormal prion protein appears in order to help determine the type of prion disease. Different types of CJD have different distribution patterns of the abnormal protein. **These tests are performed on fixed tissue.**
- **Genetic analysis**: This test determines if the patient has a genetic mutation, and therefore a familial prion disease. The genetic analysis can only determine if a case is familial (which occurs in about 10% of positive cases); in all other forms of prion disease such as sporadic, iatrogenic, or variant CJD, the genetic analysis may help to identify the specific type. This test is performed on frozen tissue or blood. If we receive sufficient amounts of frozen tissue, blood is not required.

A full diagnosis can be provided as long as the above appropriate samples are available. If one of the samples is not available, a partial diagnosis can be created.

Although we perform all of the above tests for our important research efforts on prion disease, we realize that some families may not want all of the information we collect. In particular, some families do not want to receive genetic information. Genetic mutations not only affect the patient, but also other blood relatives who could also have the mutation. It is important to discuss the psychological implications, confidentiality and insurance with them to determine if they wish to receive this information.

In order to insure that the family receives only the information they want, we are asking clinicians to consult with families to determine if they would like to receive a full or partial diagnosis. Please indicate their choice below and fax it to us at **216-368-4090**. The NPDPSC will not release genetic information until this form is returned.

Please note for blood only cases where the family wishes to receive the genetic information, please check the "full diagnosis" box to release the genetic analysis.

For questions, please contact us at **216-368-0587** or cjdsurveillance@UHhospitals.org.

✓ **Please check the appropriate box listed below:**

☐ Please send only a partial diagnosis, including the Western blot (if frozen tissue is available) and IHC/Histology (if fixed tissue is available), without the genetic analysis. The partial diagnosis will only tell if the case is positive or negative.

☐ Please send the full diagnosis, including the genetic analysis (only available if blood/frozen tissue is submitted). The full diagnosis will tell if the case is positive or negative and provide the type (sporadic and the subtype of sporadic, familial, or variant) of prion disease if the case is positive.

Patient Name: _____ Date: _____

Physician Name (print): _____Signature: _____

Physician Phone: _____ Physician Fax: _____